Massachusetts Division of Health Care Finance and Policy

Nursing Facility Quarterly User Fee Assessment Form Instructions

General Information: The "Nursing Facility Quarterly User Fee Assessment" form is a document used to calculate your facility's User Fee Assessment in accordance with regulation 114.5 CMR 12.04(1) and (2). All Class I, II III and IV Massachusetts Nursing Facilities that are licensed by the Department of Public Health (DPH) under Chapter 111 Section 71 of the Massachusetts General Laws, including nursing facilities, transitional care units, etc., are required to file. See facility class descriptions and applicable user fee rates under Section II below.

Due Dates:

Assessment period	Payment and Form Due Date
July 1 – September 30	November 1
October 1– December 31	February 1
January 1 – March 31	May 1
April 1 – June 30	August 1

Assistance: If you need help or have any questions relevant to completing this worksheet, please contact Customer Service at 800-609-7232.

Where to File: http://mass.gov/DHCFPINET

Nursing Facilities are strongly encouraged to file the "Nursing Facility Quarterly User Fee Assessment" form electronically. A "Non-Confidential Data Reporting Security Agreement" and "Attachment A: User Agreement" are required of providers who file electronically. Copies are available on the Division's website, via Online Services > INET and Report Filing Guidelines > Nursing Facilities > Nursing Facility Reports at www.mass.gov/dhcfp.

The "Non-Confidential Data Reporting Security Agreement" must be mailed to the Division at least ten days before the due date in order to process the application. In the event that the "Nursing Facility Quarterly User Fee Assessment' form cannot be filed electronically, it must be mailed to the Division. The following mailing address should be used for both purposes:

Division of Health Care Finance and Policy
Two Boylston Street, Boston, MA 02116
Attn: Patricia McCusker

I. Total Nursing Patient Days for the Quarter Ending 9/30/09:

Total Qtr NH Patient Days: Patient Day. A day of care provided to an individual patient by a Facility. A Patient Day includes the date of admission and the date of discharge if both occur on the same day. All Reserved Vacant Bed Days held, except for the period of September 1, 2003 – June 30, 2004, should be included. A Patient Day does not include the date of discharge or days of service to Residential Care residents. Effective 2/1/05, PACE and MassHealth SCO

days are considered Massachusetts Medicaid days. Hospice days should be reported based on the patient day definition in regulation 114.5 CMR 12.02. A Patient Day includes any day that has not yet been reimbursed by the insurer. The days reported on the Quarterly Assessment form should agree with the days reported on the HCF-1 cost report for that period.

Enter the patient days into the proper patient day classification by month. Column 7 is the sum on columns 1 – 5 only.

II. Calculation of the Nursing Facility User Fee Assessment:

Total Qtr Non-Medicare Days (col. 7): Enter the number of Non-Medicare Days reported in column 7 of the table in Section I onto the designated line in Section II. Using the grid below, please determine which user fee rate should be inserted on the user fee line. If you are having trouble determining your facility's class, please contact customer service at 1(800) 609-7232 or check the listing on the Division's website.

NURSING FACILITY USER FEE

Facility Class	Criteria	User Fee Effective 7/1/09 – 8/31/09	User Fee Effective 9/1/09
Class I	All facilities that do not qualify for classes 2 – 4.	$11.59	$19.17
Class II	Non-profit continuing care retirement communities and residential care facilities.	$1.16	$1.92
Class III	Non-profit nursing facilities that participate in the Medicaid program and that provided more than 66,000 annual Medicaid bed days in FY2005.	$1.16	$1.92
Class IV	Facilities that: (1) have 100 or fewer licensed beds; and (2) were established and licensed in Massachusetts prior to the enactment of the Health Insurance for the Aged Act, Pub. L. 89-97, Title I, 79 Stat. 290, and the Medicaid Act, Pub. L. 89-97, Title I, §121(a), 79 Stat. 343, on July 30, 1965; and (3) are not participating in either of the Medicare or Medicaid programs. In addition, Class IV includes homes located in Essex, Middlesex, and Suffolk counties that meet criteria (1) and (2) above but that do participate in the Medicaid program.	$0.00	$0.00

NH User Fee: Please enter the product of the reported *"Total Qtr Non-Medicare Days"* multiplied by the *"User Fee Rate"* on the designated *"NH User Fee"* line. The July, August and September Total Qtr Non-Medicare Days and NH User Fees should be summed and reported on the Total Qtr. line.

III. Comments: Please enter any additional pertinent information that you would like the Division to be aware of, such as changes in beds, significant changes in days, prior period adjustments for the reclassification of days by payer type made in the current reporting quarter, etc. When filing electronically you may be prompted to explain why your reported days are more or less than anticipated. Use this section to explain the variance. Attach additional comment pages to this form if necessary. Please enter the facility name, vendor payment number and quarter ending date on the top of each additional comment page attached to this form.

Owner, Partner, Officer or Administrator Information: Please check all of the information carefully prior to signing this form. Once you are satisfied that the information reported on the form is accurate to the best of your knowledge, sign your name, enter the date, enter your name and title on the designated lines.